

**2026  
CAMP APPLICATION  
PAGE 1**

**WESTERN NEW ENGLAND  
BASKETBALL CAMP**

**CAMP DATES ATTENDING**

- 7/20-7/24  
 BOYS  GIRLS  
 7/27-7/31  
 BOYS  GIRLS

**CAMP TUITION: \$315**

**\*According to Massachusetts General Law 105 CMR 430.000 ALL CAMPERS MUST SUBMIT, IN COMPLETION, BOTH SIDES OF THIS HEALTH FORM or a Health Care Recommendation form by a Licensed Medical Provider.**

**Camp 8:45-3:45pm**

**NOTE! INDICATE T-SHIRT SIZE:** YL AS AM AL AXL

**SECTION I (to be completed by Parent/Guardian) Grade Entering FALL 2026 (Boys & Girls 3<sup>rd</sup>-9<sup>th</sup>): \_\_\_\_\_**

Email Address: \_\_\_\_\_ \*All Camp Correspondence will be sent by email - Please PRINT

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
First Middle Last Month Date Year

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Guardian Is: Father \_\_\_\_\_ Mother \_\_\_\_\_ Other \_\_\_\_\_ Guardian Name: \_\_\_\_\_

Guardian Phone: (Day) \_\_\_\_\_ Guardian Phone: (Evening) \_\_\_\_\_

Guardian Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

In case of illness or emergency the name and telephone number of a person to contact: (Relative of Participant)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**SECTION II: Family Physician or HMO:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone: (Day) \_\_\_\_\_

Family Dentist:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone: (Day) \_\_\_\_\_

**Medical Insurance Company: REQUIRED – NOTE! PLEASE SIGN BOTH SECTIONS BELOW!!!**

Company: \_\_\_\_\_ \*\*\*Policy Number: \_\_\_\_\_

In case of medical emergency, I hereby give permission to the Camp Certified Athletic Trainer to hospitalize, to secure proper treatment for, and/or to order injection or minor surgery for my child as named above.

**SECTION II: CAMP ACTIVITIES AUTHORIZATION**  
I/We, the undersigned, for ourselves, our heirs, executors, and administrators, waive, release and forever discharge The Western New England Basketball Camp, Western New England University, and its staff, officers, agents, employees, representatives, successors, and assignees of and from all rights and claims for damages, injuries, or loss of person or property which may be sustained or occur during participation in Camp activities or while at camp.

Parent Signature **REQUIRED ABOVE** Date Parent Signature **REQUIRED ABOVE** Date

**Please Print and Complete BOTH (2) PDF Application Forms**

**A \$100 nonrefundable deposit made payable to “Western New England Basketball Camp” must accompany this application.**

**Mail application to: Western New England Basketball Camp 22 Wisteria Lane East Longmeadow, MA 01028**

**Method of Payment Cash or Check – No personal checks accepted on day of registration**

# 2026 CAMP APPLICATION PAGE 2

# WESTERN NEW ENGLAND BASKETBALL CAMP

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### SECTION III: Physical Examinations

(Must have been done by a medical provider within the preceding 24 months).

Medical History: (Please note significant disorders)

Allergies \_\_\_\_\_ Heart \_\_\_\_\_ Tuberculosis \_\_\_\_\_  
 Kidney \_\_\_\_\_ Lung \_\_\_\_\_ Diabetes \_\_\_\_\_  
 Varicella \_\_\_\_\_ Disabilities \_\_\_\_\_ Neurological \_\_\_\_\_  
 Whooping Cough \_\_\_\_\_ Other: \_\_\_\_\_

Pertinent Medical History: \_\_\_\_\_  
 \_\_\_\_\_

Child Name: \_\_\_\_\_ Birth \_\_\_\_\_

Date: \_\_\_\_\_ Summary \_\_\_\_\_  
 of Significant Treatment Program including Names/dose of Medications  
 to be used while at program:

(Medications MUST be in a container with the original label)

Health Care Provider/Physician: \_\_\_\_\_  
 \_\_\_\_\_

Signature and /or Stamp Required \_\_\_\_\_

Date: \_\_\_\_\_  
 Printed Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Person herein described has permission to engage in all prescribed camp activities  
 EXCEPT as noted here.

### SECTION IV: Immunizations

Has completed primary series of tetanus/diphtheria? (four doses) Yes \_\_\_\_\_ No \_\_\_\_\_

Primary Series - Type of Vaccine OVP IPV E-IPV \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Laser Booster - Type of Vaccine OVP IPV E-IPV \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Immunization	Dates
Diphtheria/tetanus (Td)	
Must be within last ten years	_____ / _____ / _____
Measles #1 (Rubella, Red measles)	
Must be AFTER age 12 months or	_____ / _____ / _____
MMR #1	
or	
Positive Measles Titer (Blood Test)	_____ / _____ / _____
Measles #2 (rubella, Red Measles)	
Must be at least 30 days AFTER first dose	_____ / _____ / _____
or	
MMR#2	_____ / _____ / _____
Mumps or MM#1	_____ / _____ / _____
Must be AFTER age 12 months	
or	
Positive Mumps Titer (Blood Test)	_____ / _____ / _____
Rubella (German Measles) or MMR #1	_____ / _____ / _____
Must be AFTER age 12 months	
or	
Positive Rubella Titer (Blood Test)	_____ / _____ / _____
Hepatitis B - those born AFTER 1-1-92	
Dose #1	_____ / _____ / _____
Dose #2	_____ / _____ / _____
Dose #3	_____ / _____ / _____

Medical Exemption: The above-named person does not have one or more of the required immunizations because she/he has medical problem (s) that precludes the \_\_\_\_\_  
 \_\_\_\_\_ vaccine (s)

<p style="font-size: 1.2em; font-weight: bold; margin: 0;">We Provide</p> <p style="margin: 5px 0 0 20px;">Experienced Coaches • Indoor facilities</p> <p style="margin: 5px 0 0 20px;">• Lunch • T-shirt for Every Camper* • Certified Athletic Trainer on Staff • Swimming Pool with Life Guards on duty •</p>	<p style="font-size: 1.2em; font-weight: bold; margin: 0;">You Supply</p> <p style="margin: 5px 0 0 20px;">An attitude to Learn! • Sneakers • Swim Gear and Towel</p>
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